

CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

payment**basics**

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Clinical laboratory services are tests on specimens from the body (such as blood or urine) that are used to diagnose and treat patients. Under Part B, Medicare covers medically reasonable and necessary laboratory services that are ordered by a physician or a qualified nonphysician practitioner when they are provided in a lab that is certified by the Centers for Medicare & Medicaid Services (CMS). With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Covered screening tests (with some restrictions) include screening tests for cardiovascular disease and colorectal, prostate, and cervical cancer.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs.¹ Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these tests are paid under other Medicare payment systems.

The majority of lab services do not involve the work of a physician; these services are paid under the Clinical Laboratory Fee Schedule (CLFS), which is described in this document. Unlike most other Medicare services, there is no beneficiary cost sharing for CLFS services. In 2018, Medicare spending for lab services totaled \$8.8 billion. Lab services that include physician work, such as surgical pathology, are paid under the fee schedule for physicians and other health professionals and are described in a separate document—*Medicare Payment Basics: Physician and Other Health Professional Payment System*.

Defining the product Medicare buys

Medicare sets payment rates for roughly 1,400 Healthcare Common Procedure Coding System (HCPCS) codes used in the CLFS. A single HCPCS code may identify

more than one testing method for a given substance or more than one substance analyzed by a single method.

Setting the payment rates

Prior to 2018, CLFS payment rates were largely based on historical laboratory charge data that were capped and then inflated over time. In response to evidence suggesting that Medicare's CLFS payment rates were excessive, the Protecting Access to Medicare Act (PAMA) of 2014 required the CLFS to be based on private payer rates.

Pursuant to PAMA, beginning in 2018, CMS sets CLFS rates based on the weighted median of private payer rates. CMS establishes a weighted median for each HCPCS code based on private payer payment rates and volume data reported by applicable laboratories. In order to be considered an applicable laboratory, an entity must meet the definition of a laboratory established by the Clinical Laboratory Improvement Amendments (CLIA), bill Medicare Part B under its own National Provider Identifier (NPI), receive a majority of its Medicare revenues from the CLFS or the physician fee schedule, and meet the low expenditure threshold.² For 2019, CMS established CLFS payment rates based on payments applicable laboratories received from private payers from January through June 2016, which is referred to as the data collection period. As required by statute, CMS established a phase-in of the private payer-based CLFS rates. Specifically, for 2018 through 2020, payment rate reductions cannot be more than 10 percent per year for an individual service, and, for 2021 through 2023, reductions cannot be more than 15 percent per year.

The new CLFS payment rates are national and do not vary based on geography. In addition, the payment rates are not adjusted annually based on inflation.

*This document does not
reflect proposed legislation
or regulatory actions.*

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Instead, for most services, payment rates will be in effect for three years, after which CMS will institute revised payment rates based on new data collected from laboratories. For new laboratory tests and those for which CMS receives no private payer information, CMS establishes payment rates using “crosswalking” or “gapfilling” methodologies. Under the “crosswalking” methodology, the payment rate for a laboratory service is established based on the rate of a similar service or combination of services. “Gapfilling” is used when no similar service exists and involves setting payment rates on information such as charges, discounts to charges, and resources required to perform the test.

In addition to changing the manner in which Medicare sets payment rates for laboratory services, PAMA also established a new subcategory of laboratory services, referred to as advanced diagnostic laboratory tests (ADLTs), to which special payment rules apply. ADLTs are tests that are only offered by a single laboratory

and meet other criteria, such as being an analysis of multiple biomarkers of DNA or RNA that provides new clinical diagnostic information that cannot be obtained from any other test or combination of tests.

The CLFS payment rate for a new ADLT is equal to the product’s actual list charge for three calendar quarters. After this time period, the payment rate for an ADLT is set at the weighted median of private payer rates, but unlike the payment rates for other laboratory services, CMS will collect new private payer data and establish a new payment rate for an ADLT every year instead of every three years. ■

- 1 Beginning in 2014, payments for many laboratory tests provided in hospital outpatient departments are packaged with an associated visit or procedure and are no longer paid separately under the CLFS.
- 2 A laboratory meets the low expenditure threshold if it receives at least \$12,500 in Medicare revenues from the CLFS during the data collection period. A hospital outreach laboratory does not need to bill under its own NPI to be considered an applicable laboratory. Instead, such labs can be identified based on their billings under the CMS-1450 14x type of bill.